

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SS# \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Please attach copy of front and back of patient's prescription ins. card(s) if applicable  
Insurance Company Name: \_\_\_\_\_  
Insurance Company Phone: \_\_\_\_\_  
Policy holder: \_\_\_\_\_  
Policy holder Employer: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_  
RxBIN: \_\_\_\_\_ RxPCN: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_  
DEA# \_\_\_\_\_ NPI# \_\_\_\_\_  
License#: \_\_\_\_\_ Medicaid UPIN#: \_\_\_\_\_  
Physician Specialty: \_\_\_\_\_  
☒ **Ship Product to: Physician or Clinic**  
Office Contact: \_\_\_\_\_  
Date Shipment Needed: \_\_\_\_\_  
Shipment Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*If shipped to the physician's office, physician accepts on behalf of patient for administration in office.*

**CLINICAL INFORMATION**

Diagnosis:  
☐ 715.16 Primary localized OA, lower leg ☐ 715.26 Secondary localized OA, lower leg  
☐ 715.36 Localized OA, NOS, lower leg ☐ 719.46 pain in joint, lower leg  
☐ Other: \_\_\_\_\_  
Patients Allergies: \_\_\_\_\_  
Patient Height: \_\_\_\_\_ Patient Weight: \_\_\_\_\_  
Previous/Current Therapies:  
Acetaminophen/NSAID/COX-2 Inhibitors: ☐ Current ☐ Failed  
Intra-articular corticosteroid injection: ☐ Current ☐ Failed  
Physical Therapy: ☐ Current ☐ Failed  
Surgical Procedures (i.e. debridement, arthroscopy): ☐ Current ☐ Failed  
Has the patient had any sodium hyaluronate in the past? ☐ Yes ☐ No  
If yes, what was the site of injection? ☐ Right Knee ☐ Left Knee ☐ Bilateral Knees  
If yes, has it been less than 6 months since the last sodium hyaluronate injection for the SAME knee? ☐ Yes ☐ No  
Date of Last Injection: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

☐ EUFLEXXA® (1% SODIUM HYALURONATE) 20MG/2ML PFS  
☐ HYALGAN® (SODIUM HYALURONATE) 20MG/2ML (**Please select**): ☐ VIAL ☐ PFS  
☐ ORTHOVISC® (SODIUM HYALURONATE) 30MG/2ML PFS  
☐ SUPARTZ® (SODIUM HYALURONATE) 25MG/2.5ML PFS  
☐ SYNVISCO-ONE® (HYLAN G-F 20) 48MG/6ML PFS  
☐ SYNVISCO® (HYLAN G-F 20) 16MG/2ML PFS  
SIG: Inject intra-articular into ☐ RIGHT ☐ LEFT ☐ BILATERAL Knee(s)  
ONCE PER WEEK for a total of # \_\_\_\_\_ injections by physician.  
**X** \_\_\_\_\_  
Physician Signature (no stamps) \_\_\_\_\_ Date \_\_\_\_\_  
If physician requests Brand Name only, DAW  
MUST be HANDWRITTEN in the following space provided: